Exhibit 17

Jeff S. Pierce, D.O.
Michigan Sport and Spine Center
1819 E. Big Beaver Rd., Suite 210
Troy, MI 48083

Patient: Redacted
Sex: Male
Ref. M.D.: DR. KARRUMI
D.O.B. Redacted

Physician: Jeff S. Pierce, D.O.
Test Date: 12/17/10

Motor Nerve Study

Peroneal Nerve
Rec Site: EDB

STIM SITE	Lat (ms) L	Lat (ms) R	Dur (ms) L	Dur (ms) R	Amp (mV) L	Amp (mV) R	Area (mVms) L	Area (mVms) R	Dist (mm) L	Dist (mm) R	C.V. (m/s) L	C.V. (m/s) R
Ankle	5.5	5.8			1.7	2.2			0	0		
B.Fibular	13.4	14.8			2.7	5.5			370	375	46.7	42.1

Sensory Nerve Study

Sural Nerve
Rec Site: Ankle

STIM SITE	Lat (ms) L	Lat (ms) R	Pk Lat (ms) L	Pk Lat (ms) R	Amp (uV) L	Amp (uV) R	Dist (mm) L	Dist (mm) R	C.V. (m/s) L	C.V. (m/s) R
mid calf	3.1	3.0	4.1	4.0	9.8	7.1	0	0		

F-Wave Study

Peroneal Nerve
Rec Site: EDB
Stim Site: Ankle

	Latency ms L	Latency ms R	Amplitude mV L	Amplitude mV R
M wave	13.83	15.00	3.75	9.17
F wave	48.67	46.50	1.50	1.50
F-M	34.83	31.50		

H Reflex Study

Nerve
Rec Site: Soleus
Stim Site: Pop.Fos.

	Latency ms L	Latency ms R	Amplitude mV L	Amplitude mV R
M wave	4.83	5.00	3.50	3.60
H wave	34.00	33.67	2.50	2.50

EMG Study

Name	Ins Act	F-Waves	Fascics	Fibs	Rep	MC.amp	MC.amp	MU dur	Phasics	Rec Pat	TEXT
L. Vastus Med.											

01/27/2011 13:50 FAX 0457/053

STATE FARM INSURANCE
FAX 888-845-8680
PO BOX 2361
BLOOMINGTON IL 61702

CARRIER

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22B177093

2. Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX M X F

4. Redacted

5. Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. Redacted

8. PATIENT STATUS: Single Married X Other; Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO X

b. AUTO ACCIDENT? YES X NO PLACE (State) MI

c. OTHER ACCIDENT? YES NO X

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH: Redacted SEX M X F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 01 06 11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: 07 29 10

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JEFF SCOTT PIERCE DO

17a. 17b. NPI 1235103771

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO X $ CHARGES 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 722 0
2. 724 4
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 17 10	12 17 10	11		95861	12	600 00	1		NPI	1235103771
2	12 17 10	12 17 10	11		95903	12	500 00	2		NPI	1235103771
3	12 17 10	12 17 10	11		95900	12	400 00	2		NPI	1235103771
4	12 17 10	12 17 10	11		95904	12	370 00	2		NPI	1235103771
5	12 17 10	12 17 10	11		95934	12	350 00	2		NPI	1235103771
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 205918486 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 10290C3658

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE $ 2220 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 2220 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JEFF SCOTT PIERCE DO
SIGNED DATE 01 11 11

32. SERVICE FACILITY LOCATION INFORMATION
MICHIGAN SPINE & REHAB DT
23861 MCNICHOLS
DETROIT MI 48219
a. 1518027606 b.

33. BILLING PROVIDER INFO & PH. # 248 8894580
MICHIGAN SPINE AND REHAB
5761 W MAPLE RD
WEST BLOOMFIELD MI 48322
a. 1518027606 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS

Michigan Spine & Rehab
23861 W. McNichols
Detroit, MI 48219
(313) 769-9869

Patient: Redacted
Sex: Female
S.S. No. Redacted
Ref. M.D.: THAKUR
D.O.B. Redacted

Physician: Jeff S. Pierce, D.O.
Test Date: 02/04/11

Motor Nerve Study

Left Median-Ulnar Nerve

Rec Site: APB-ADM	Lat (ms)	Dur (ms)	Amp (mV)	Area (mVms)	Dist (mm)	C.V. (m/s)
STIM SITE						
M Wrist	5.2		7.3		0	
Elbow	9.8		5.7		280	49.3

Median-Ulnar Nerve

Rec Site: APB-ADM	Lat (ms)		Dur (ms)		Amp (mV)		Area (mVms)		Dist (mm)		C.V. (m/s)	
STIM SITE	L	R	L	R	L	R	L	R	L	R	L	R
M Wrist		4.2				4.7			0	0		
Elbow		8.4				2.4				215		50.6
U Wrist	4.0				7.9				0			
B.Elbow	7.2				7.7				235		74.2	
A.Elbow	10.3				7.2				145		47.0	

Right Median-Ulnar Nerve

Rec Site: APB-ADM	Lat (ms)	Dur (ms)	Amp (mV)	Area (mVms)	Dist (mm)	C.V. (m/s)
STIM SITE						
U Wrist	4.2		3.8		0	
B.Elbow	7.3		10.6		230	72.6
A.Elbow	9.9		4.7		125	48.4

Sensory Nerve Study

Med/Ulr/Rad Nerve

Stim Site: Wrist	Lat (ms)		Dur (ms)		Amp (uV)		Dist (mm)		C.V. (m/s)	
REC SITE	L	R	L	R	L	R	L	R	L	R
M Thumb	4.5	3.2			7.3	105.3	0	0		
R Thumb	1.6	3.0			21.7	9.3	0	0		
Index	4.8	3.4			13.7	21.7	0	0		
D2 MdPalm	5.0	1.8			3.7	18.3	0	0		
5th dig	4.7	4.1			1.7	5.0	0	0		

F-Wave Study

Median-Ulnar Nerve

Rec Site:	Latency ms		Amplitude mV	
Stim Site:	L	R	L	R
M wave	5.00	4.00	10.08	8.25
F wave	33.83	34.25	15.00	15.00
F-M	28.83	30.25		

STATE FARM INSURANCE
FAX 888-845-8680
PO BOX 2361
BLOOMINGTON IL 61702

1500
HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22B178522

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

6. PATIENT STATUS: Single [ ] Married [ ] Other [X]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

7. INSURED'S POLICY GROUP OR FECA NUMBER

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH SEX

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [X]
c. OTHER ACCIDENT? YES [ ] NO [X]

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: Redacted

a. INSURED'S DATE OF BIRTH SEX: Redacted M [ ] F [X]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

d. INSURANCE PLAN NAME OR PROGRAM NAME: BLUE CROSS/BLUE SHIELD

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 02 04 11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JEFF SCOTT PIERCE DO

17a.

17b. NPI 1235103771

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 722.0
2. 723.4
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 04 11	02 04 11	11		95861		12	600 00	1		NPI	1235103771
2 02 04 11	02 04 11	11		95904		12	1110 00	6		NPI	1235103771
3 02 04 11	02 04 11	11		95900	59	12	800 00	4		NPI	1235103771
4 02 04 11	02 04 11	11		95903		12	500 00	2		NPI	1235103771
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 205918486 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 18870C4688

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 3010 00

29. AMOUNT PAID: $ 42 40

30. BALANCE DUE: $ 1048 63

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JEFF SCOTT PIERCE DO
SIGNED 02 17 11 DATE

32. SERVICE FACILITY LOCATION INFORMATION
MICHIGAN SPINE & REHAB DT
23861 MCNICHOLS
DETROIT MI 48219
a. 1518027606 b.

33. BILLING PROVIDER INFO & PH. # (248) 8894580
MICHIGAN SPINE AND REHAB
5761 W MAPLE RD
WEST BLOOMFIELD MI 48322
a. 1518027606 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WRAP-IDENV / WRAP-IDENV-98

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-160005

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BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

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The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records." Federal Register Vol. 55 No. 40, Wed Feb 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Michigan Spine & Rehab
23881 W. McNichols
Detroit, MI 48219
(313) 769-8888

Patient: Redacted
Sex: Female
S.S. No.
Ref. M.D.: DR. ONIANGO
D.O.B. Redacted

Physician: Jeff S. Pierce, D.O.
Test Date: 03/16/11

Motor Nerve Study

Left Median-Ulnar Nerve Rec Site: APB-ADM	Lat (ms)	Dur (ms)	Amp (mV)	Area (mVms)	Dist (mm)	C.V. (m/s)
STIM SITE						
M Wrist	4.7		4.5		0	
Elbow	9.9		9.1		180	245.0

Median-Ulnar Nerve Rec Site: APB-ADM	Lat (ms)		Dur (ms)		Amp (mV)		Area (mVms)		Dist (mm)		C.V. (m/s)	
	L	R	L	R	L	R	L	R	L	R	L	R
STIM SITE									0	0		
M Wrist		8.2				8.7			0	185		44.4
Elbow	20.8	9.3			21.5	1.1			0			
U Wrist	3.3				6.8				0			
B.Elbow	8.5				6.6				210		64.8	
A.Elbow	8.8				5.1				105		48.7	

Right Median-Ulnar Nerve Rec Site: APB-ADM	Lat (ms)	Dur (ms)	Amp (mV)	Area (mVms)	Dist (mm)	C.V. (m/s)
STIM SITE						
U Wrist	3.6		7.2		0	
B.Elbow	15.8		5.0		220	18.9
A.Elbow	21.2		14.7		120	6.5

Sensory Nerve Study

Med/Ulnar Nerve Stim Site: Wrist	Lat (ms)		Dur (ms)		Amp (uV)		Dist (mm)		C.V. (m/s)	
REC SITE	L	R	L	R	L	R	L	R	L	R
M Thumb	3.5	3.6			39.9	29.9	0	0		
R Thumb	3.0	3.2			10.7	8.8	0	0		
Index	3.5	3.7			18.0	29.0	0	0		
D2 M/Palm	3.0	1.9			89.3	42.7	0	0		
5th dig		3.3				20.7		0		

F-Wave Study

Median-Ulnar Nerve Rec Site: Stim Site:	Latency ms	
	L	R
M wave	4.75	3.33
F wave	32.25	33.58
F-M	27.50	30.25

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
FAX 888-845-8680
PO BOX 2361
BLOOMINGTON IL 61702

CARRIER

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22B149302

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 03 16 11

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: JEFF SCOTT PIERCE DO
17a.
17b. NPI 1235103771

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 723 1
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 16 11	03 16 11	11		95861		1	600 00	1		NPI	1235103771
2 03 16 11	03 16 11	11		95904		1	1110 00	6		NPI	1235103771
3 03 16 11	03 16 11	11		95900	59	1	800 00	4		NPI	1235103771
4 03 16 11	03 16 11	11		95903		1	500 00	2		NPI	1235103771
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 205918486 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 21700C6527

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 3010 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 3010 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JEFF SCOTT PIERCE DO
03 31 11
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
MICHIGAN SPINE & REHAB DT
23861 MCNICHOLS
DETROIT MI 48219
a. 1518027606 b.

33. BILLING PROVIDER INFO & PH. # (248) 8894580
MICHIGAN SPINE AND REHAB
5761 W MAPLE RD
WEST BLOOMFIELD MI 48322
a. 1518027606 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WRCF-RI-ERV / WRCF-10-ERV-SS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

Michigan Spine and Rehab
23861 W McNichols
Detroit, MI 48219

Electrodiagnostic Report
EMG/NCV

Patient Name:	Redacted
Recording Date:	6/28/2012
Birth Date:	Redacted
Ref Doctor:	Dr. Fitch
History:	Pt is right-handed, and she c/o b/l posterior cervical pain and b/l upper extremity pain, paresthesias and weakness extending into all of her fingers of both of her hands. She also c/o b/l low back pain and b/l lower extremity pain, paresthesias and weakness extending posteriorly to her heels. This all began ~ 3 years ago.

IMPRESSIONS BILATERAL UPPER EXTREMITIES

1. Abnormal study.
2. Electrodiagnostic evidence suggestive of bilateral C6-C7 radiculitis.
3. Electrodiagnostic evidence of right median sensorimotor neuropathy consistent with moderate right carpal tunnel syndrome.
4. Electrodiagnostic evidence of left median sensory neuropathy consistent with mild left carpal tunnel syndrome.
5. Electrodiagnostic evidence of ulnar sensory neuropathy bilaterally.
6. No electrodiagnostic evidence of ulnar motor neuropathy bilaterally.
7. No electrodiagnostic evidence of radial neuropathy bilaterally.
8. No electrodiagnostic evidence of cervical myopathy or plexopathy bilaterally.

IMPRESSIONS BILATERAL LOWER EXTREMITIES

1. Abnormal study.
2. Electrodiagnostic evidence suggestive of bilateral L5-S1 radiculitis.
3. No electrodiagnostic evidence of peroneal motor neuropathy bilaterally.
4. No electrodiagnostic evidence of tibial motor neuropathy bilaterally.
5. Electrodiagnostic evidence of sural sensory neuropathy on the right.
6. No electrodiagnostic evidence of sural sensory neuropathy on the left.
7. No electrodiagnostic evidence of lumbar myopathy or plexopathy bilaterally.

Thank you for the opportunity to participate in the care of your patient.

Sincerely,

Katherine H. Karo, DO
Physical Medicine & Rehabilitation

10ch1218600252

Redacted

GB12L53DBW

6/28/2012 11:37:28 AM

MNCV	Site/Segment	Latency ms	Amp mV	Dur ms	Area mVms	Distance mm	Velocity m/s
Median R	Wrist-APB 7cm	7.9	1.8	9.3	8.0		
	Elbow-Wrist	11.9	1.2	3.4	1.7	210	52.9
Ulnar R	Wrist-ADM 7cm	2.7	5.0	7.3	19.5		
	Below Elbow-Wrist	6.9	7.8	7.9	26.0	220	52.6
Median L	Wrist-APB 7cm	4.2	5.2	8.0	25.1		
	Elbow-Wrist	8.1	6.6	8.0	25.4	190	48.2
Ulnar L	Wrist-ADM 7cm	3.1	6.8	7.2	23.8		
	Below Elbow-Wrist	7.4	5.6	8.9	21.1	220	51.5
Peroneal R	Foot-EDB 9cm	3.3	5.1	8.4	16.8		
	Below Fib Head-Foot	10.1	4.0	7.3	10.5	300	44.3
Tibial R	Ankle-AH 8cm	5.3	6.1	5.5	18.2		
	Pop Fossa-Ankle	13.5	7.0	6.3	5.7	400	48.9
Peroneal L	Foot-EDB 9cm	3.4	5.4	6.2	16.7		
	Below Fib Head-Foot	10.3	4.4	6.4	11.0	320	46.4
Tibial L	Ankle-AH 8cm	4.5	6.0	5.4	13.0		
	Pop Fossa-Ankle	12.5	1.3	7.4	1.0	400	49.6

SNCV	Site/Segment	Latency ms	Amp uV	Dur ms	Area uVms	Distance mm	Velocity m/s
Median Dig II R	Wrist-Digit II 14cm	2.1	0.00				NO
Ulnar Dig V R	Wrist-Digit V 14cm	3.5	5.53			140	40.6
Radial Snuff box R	Forearm-Snuff Box 10cm	2.2	9.11			110	50.0
Median Dig II L	Wrist-Digit II 14cm	4.5	10.4			160	35.9
Ulnar Dig V L	Wrist-Digit V 14cm	3.7	19.0			150	40.5
Radial Snuff box L	Forearm-Snuff Box 10cm	2.4	14.9			110	45.8
Sural R	Gastroc-Lat Mall 14cm	6.4	15.0			140	22.0
Sural L	Gastroc-Lat Mall 14cm	3.1	12.6			140	45.9

F Wave	F min latency ms
Median R	29.7
Ulnar R	30.7
Median L	26.8
Ulnar L	28.2
Peroneal R	48.3
Tibial R	48.2
Peroneal L	45.5
Tibial L	35.0

H Reflex	H Latency ms
Tibial R	37.4
Tibial L	37.2

10ch1218600254